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The Theater of Birth: Scenes from Women's Scripts

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Abstract

An analogy between theater and birth is drawn from analyses of women's birth stories to describe birth from a fresh perspective. Birth and theater are compared using the theatrical production

elements: setting, casting, props, set, behind the scenes, script, and roles. Selected examples from women's birth stories highlight each element. Nurses' roles are significant during labor and birth, but nurses' abilities to fulfill these roles are threatened. This analogy promotes rethinking of nursing actions in the theater of birth. Implications for clinical practice are provided, including altering the birth environment, offering choices, and maintaining the woman's role as star.

Key words

birth stories; caring behaviors; childbirth; labor and delivery

INTRODUCTION

In recent discussions about perinatal nursing, authors have emphasized the importance of nurses' support during labor and birth.^{1,2} Nurses play a significant and quite autonomous role in the management of labor in most settings.³ The role of the nurse also figures prominently in the birth stories of most women. However, it has become more difficult for nurses to attend to women's needs because of reduced staffing and other demands on their time.⁴ This change in workload complicates the nurses' sense of the specific role expectations that need to be fulfilled. Women's perceptions of caring behaviors differ from those of nurses.⁵ Understanding these differences can assist nurses in better focusing their limited time and multiple complex demands.

When people think about labor and birth, they often focus on the event of most interest to them, the product of the birth (the infant). However, it is clear that for women, the entire experience of labor and birth is a profound life event that nurses and other providers affect. There is much to be learned from the individual and collective stories about the drama of the birthing experience. The importance of listening to women to better understand their birth experiences has been established.⁶⁻⁹ Birth story data in general provide a record of women's experiences during labor, including their views about their caregivers.

The purpose of this article is to provide a fresh look at birth and allow for a fuller picture of the multiple dimensions of the experience that are derived from birth story data. The authors determined that birth story data lend themselves to a theatrical interpretation because these data are often constructed like a script or screenplay, with a plot, a cast, and dialogue. The commonalities between theater and birth allowed the authors to conceptualize an analogy. A thematic reanalysis of the birth story data allowed for the theatrical interpretation.

The analogy between theater and birth is based on scientific literature and women's perspectives drawn from their birth stories (reanalysis). The two samples were not compared for historical effect. The birth stories that are used in this paper were collected from two research studies using data solely from women in the midwestern United States of America (USA).⁸⁻¹⁰ These studies were undertaken to describe women's experiences from their own words. During unstructured interviews, women were encouraged to tell the stories of their labors and births in any way they wished. The sample characteristics of the two qualitative studies are presented in Table 1. A total of 84 birth stories told by 37 women constitute the data for this analogy. There were more stories than women because multiparas told the stories of all of their births. Both samples were deliberately nonrepresentative to increase diverse perspectives thereby augmenting the analysis and insights gained. Table 2 contains

demographic characteristics of the samples. For the purpose of this paper, the qualitative data were used as examples for each element of the analogy. The analogy provides a unique way to present data about birth from the women's perspective that can enhance nurses' reflection on the roles they perform during labor.

Table 1 Two samples triangulated for the analysis: Participants in qualitative studies of women's birth stories

Characteristic	VandeVusse (1993)	Harrod (1998)	Total sample (%)
Number of women interviewed	15	22	37 (100.0%)
Number of birth stories analyzed	33	51	84 (100.0%)
Type of health care provider:			
• MD	21	45	66 (78.6%)
• CNM	3	5	8 (9.5%)
• Lay midwife	8	1	9 (10.7%)
• Other (RN, partner)	1	0	1 (1.2%)
Place of birth:			
• Hospital	22	51	73 (86.9%)
• Home	11	0	11 (13.1%)
• Birth center	0	0	0 (0%)

Table 2 Demographic characteristics of the birth story study participants

Sample characteristic	VandeVusse n=15	Harrod n=22	Total (%) n=37
Parity			
• Primiparas	8	7	15 (41%)
• Multiparas	7	15	22 (59%)
Marital status			
• Married	10	21	31 (84%)
• Single	5	1	6 (16%)
Ethnicity			
• European heritage	12	18	30 (81%)
• Various other ethnic backgrounds	3	4	7 (19%)
Employment			
• As homemaker	6	11	17 (46%)
• Part-time outside home	6	6	12 (32%)
• Full-time outside home	3	5	8 (22%)
Age in years			
Range	18-39	17-42	17-42
Mean	28.2	30.9	29.8
Education (Years completed)			
Range	11-16	11-18	11-18
Mean	13.9	15.3	14.7

Theater is a dramatic representation as an art form. Table 3 contains a comparison of theater and birth in an abbreviated format and contains the production elements of theater used in the analogy with birth: setting the stage, casting, costuming, props, set, behind the scenes, script, and roles. A definition is given for each production element of theater within the body of the paper. Examples from birth story data are presented and implications for perinatal nurses are addressed.

Table 3. The theater analogy to birth

Production element	Theater	Labor and Birth
Setting the stage	<ul style="list-style-type: none"> • Actors make stories visible for public viewing • Actors become comfortable on the stage 	<ul style="list-style-type: none"> • The stage for most births in the USA is the hospital • The staff are accustomed to the stage • Low-risk women in hospitals experience a variety of interventions, both necessary and unnecessary
Casting	<ul style="list-style-type: none"> • Roles are assigned to actors • Roles hold different degrees of importance • The star is clearly determined and acknowledged 	<ul style="list-style-type: none"> • Cast members frequently change during labor • Roles hold differing degrees of power • Nurses' roles, including caring behaviors demonstrated, were valued and praised by birthing women • The woman is central, but others may be considered "stars"
Costumes	<ul style="list-style-type: none"> • The costume designer decides what the actors wear • Costumes are worn to create an effect • Costuming helps the audience know who is who 	<ul style="list-style-type: none"> • Custom and hospital policy dictate the attire • Hospital attire such as scrubs may be color-coded • In out-of-hospital birth, the woman decides her attire • Costumes matter less to women than caring behaviors
Props	<ul style="list-style-type: none"> • Props are objects that strengthen the story • They are rarely used if unnecessary to the story line 	<ul style="list-style-type: none"> • Props are present in the hospital setting and are often used to intervene in the birth process • Some props assist a woman to use alternative positions • Props may be supplied by the birthing woman (Lamaze bag) or

		creatively used by the intrapartum nurse
Set	<ul style="list-style-type: none"> • The background is formed with specific scenery • Noise, lights, and movement in the audience may distract the actors and/or the audience 	<ul style="list-style-type: none"> • The set (environment) may be unfamiliar to the woman • Noise, lights, and unfamiliar people may distract the woman

SETTING THE STAGE

The first element of theater involves setting the stage. Something placed on a stage is made visible for public viewing. The stage set for most births in the USA is the hospital, where most births are physician attended.¹¹ Despite the fact that childbirth education classes are available to many women, not all women participate. Even those who do may not be well prepared to be active birth participants.¹² They may not expect to make decisions about their care and may willingly give control of their experiences to others.

Women commonly encounter a number of technologies, such as blood pressure machines, infusion pumps, thermometers, epidurals, and continuous electronic fetal monitors, in the course of their birth experience. These may serve as props that help set the stage, particularly during hospital births. Some of these technologies are used to intervene during labor and birth in multiple ways, such as attempting to speed the process. The World Health Organization Technology Working Group¹³ has itemized lists, supported by research, of practices that may be beneficial and of those that may be harmful when used in normal birth. In the United States there is a negative trend toward increased use of unnecessary childbirth interventions.^{14,15} For low-risk women's births, less technology and a more woman-centered approach may be more appropriate. This concept was supported with scientific evidence presented in the Cochrane Library¹⁶ and summarized in the book *Effective Care in Pregnancy and Childbirth*.¹⁷ A number of meta-analyses presented in the Cochrane collaboration document that many commonly used childbirth interventions have not been shown to be beneficial. Further, evidence is lacking to support the safety and efficacy of a number of commonly used perinatal practices (e.g., lithotomy position for the second stage of labor¹⁸ or liberal use of episiotomy.¹⁹ Conversely, a number of care practices have documented benefits, with effectiveness demonstrated by evidence from randomized controlled trials (e.g., support from caregivers during childbirth).²⁰

CASTING: ROLE ASSIGNMENT

In theater terminology, casting involves the assignment of roles to actors. There are many actors in the theater of birth. Understanding the roles of each actor can be confusing for the laboring woman. In hospital births in the USA, health care providers involved in the birthing experience may serve in the role of star, supporting cast, director, and/or producer. They may attempt to control what other cast members, including the birthing mother, do in the production. In contrast, other cast members listen to women and encourage them to direct their own performances.⁸ In their birth stories, women acknowledged how much the roles of other actors affected them. For example, one woman described

how sensitive she was to input from others, stating that one word or touch could make a large difference to her, affecting how smoothly her labor went.⁹

Women often praised nurses in the birth story data, emphasizing several characteristics of nurses they found helpful, such as being available, protective, encouraging, informative, trustworthy, and calm. These selected examples are shown in Table 4.

Table 4. Characteristics of nurses identified by women in their birth stories

Characteristic	Quotation
Available	She [the nurse] explained everything to me in great detail....She was real helpful telling me what to expect, "Since this is your first baby, I am going to be in the room with you unless you kick me out." I thought that was great because I had no idea what to expect.
Protective	She [the nurse] was very confident, and very competent, and gave me the impression, "I am not going to let anything happen to either of you here." [I thought,] "I am going to be taken care of," and I believed her.
Informative	I asked her, "Can I have something for pain?" She was very sympathetic in the way that she explained, "No, it's past that point." So she was not just saying you cannot have something; she explained why. That was really nice.
Trustworthy	She was always there and I knew when she wasn't, she knew what I was doing. ...One of the first things she said was, "I know you have had a baby before and I am really going to listen when you tell me you have to push, because you have been through this before...Don't worry, I am believing everything you say. If you feel like you have to push, I'm putting those gloves on." She put me at ease right at the beginning. I knew she was going to be there and that if I need something I wasn't going to have to worry about asking for it, and if I put my light on, she was going to come right away.
Encouraging	I think [I liked] just her smile and support ... saying you are doing a good job, you are doing wonderful, just kind of reassuring me that I am doing all right. ...I knew she was there and not...talking down to me. She told me I was doing a great job.
Calm	Once I got back to bed I was getting overwhelmed, but because of these two nurses being very calm and quiet and not all this franticness like I had with my first baby, that helped tremendously. I would have to say it was much nicer to have those four women there, the two being very unobtrusive and the other two really getting me focused. So it worked out actually better that these women did do this [birth] rather than a doctor that I did not know. I did not get the sense that one of them was over another or anything like that, it was really good team work. They knew what they were doing and I just felt that they worked well together.

Also, women often noticed the actors (staff) changing during the course of their labors. This was particularly distracting to one primigravida. Although staff members were polite and introduced new people coming into the birthing room, the woman had trouble integrating them into her experience.

I just didn't want to focus on anybody else. There was some point at which a lab technician came in to draw my blood, and I just was wailing at that point. I just thought, "Oh, no, another person," and "I can't deal with it." So she got the hint, and she said, "Well, I'll come back later." That disturbed me, every time the contractions got harder and another person would come in or would change shift, or whatever. They changed nurses it seemed like two or three times during the night, and none stayed around and did much. But by the time they introduced me to another nurse, that seemed really distracting to me. I just kind of wanted to deal with, stay with one group, and have everybody focused on me.

In her view, changing staff distracted her and took the central focus away from her. Another woman resented the late arrival of the physician, preferring the nurse who had been attending her rather than adjusting to a new cast member: "The doctor got mad. I think that [the doctor] got offended because I was listening to the nurse and I wouldn't listen to a darn word the doctor said; she was so mean!! [The nurse] was delivering the baby and then she [the doctor] comes in. A little too late. [The nurse] answered my questions; she was smart; she knew what she was talking about."

The supporting cast introduces many other players. In some births this can seem like a cast of thousands. However, a large group of cast members does not ensure that a woman will conclude that she received better nursing care. As another woman stated, "I don't know why I had so many different nurses, but I had four different nurses and a resident nurse. And I was kind of like, who is coming in here next? And they came in and checked what they needed to check and left and I felt like I couldn't ask them questions or get help from them."

A large cast may detract from the laboring woman's role as the central player. Many people in the room having side conversations can focus attention away from the woman. Realistically, most women will have to deal with multiple providers during labor. However, nurses can assist them by minimizing staff changes, especially late in labor. In some instances women also expected the nurses to have a sense of when to be present and when not to be. As one woman explained,

Those nurses were so helpful. They will do anything for you. They do things that I would never even think of doing. And they were just very helpful, getting anything you need. I never felt like I was imposing on them or anything, which makes it so much more comfortable. My husband and I were very pleased with the nurses. They came in and out, because that would be too much if they were just kind of sitting there all the time. I wouldn't like that.

In contrast, there were times when there was no supporting cast: "They were like really busy and [my husband] would say, 'Try coming in and checking on us,' and I go, 'Honey, that's okay.' But my husband thought that someone would be coaching us a lot better. I was in so much pain and nobody was there to help coach us."

In this story, the mother reported that she and the infant's father concluded that the labor might not have ended with a Cesarean birth had the cast members actively supported them. In contrast, some women reported that the nurses were readily available and often stayed beyond their shift to provide care.

In a dramatic plot, the main characters are identified, including the leading role (star). Unfortunately, if providers assume they are the stars, they may dominate the scene. Various roles have differing degrees of power and rank related to stardom. In some cases, the nurse may be the director for the entire labor only to turn the management of the delivery over to the physician, who is declared the star. Women, however, may wish to star in their own births.

Authoritative knowledge about birth is what providers learn from their education and experience. Authoritative knowledge has been considered the especially valued contribution of professionals. However, Jordan ²¹ proposed that the woman's own knowledge, based on her bodily changes, also be valued as important information. Therefore, a nurse can help make the labor experience positive by remembering that women want to be heard and believed when sharing their embodied knowledge. As one woman explained,

The doctor walked out of the room and I said, "Look," because it was right after he [the doctor] broke my [bag of] water. I said, "I got to push. I know I have to be really close." She [the nurse] told the doctor that I thought I was ready and he said, "She [the patient] shouldn't be." And she [the nurse] was like, "Been there, done that. I am checking."

When nurses respect the woman's input as central to the action, they support her starring role while maintaining the critical importance of the nurses' role in the cast as client advocate.

As Harrod ¹⁰ demonstrated, one method of categorizing the parts nurses play during labor and birth is describing the caring behaviors reported in women's birth stories. Harrod found three main caring behavior themes in the parts nurses played: relationship, facilitation, and surveillance. When a woman reported her nurse played a caring part, it was because that nurse demonstrated that she adequately formed a relationship with the mother, facilitated the labor process, and kept the mother and baby safely under surveillance. These caring behaviors are expectations for the cast members, primarily nurses, who are providing labor support.

COSTUMES

In theater, costume designers decide what actors wear. Costumes are outfits worn to create a particular effect. They help the audience distinguish one character from another. In the theater of birth, custom and policy most often determine the attire of the characters. However, in out-of-hospital births, women tend to dress as they wish, although their providers may wear special attire and use gloves.

As "insiders," nurses and other care providers know the meaning of institutional attire. In some settings, various staff members wear color-coded costumes to help distinguish their characters. Yet with the nearly universal use of scrub clothes today, it may be difficult to differentiate among cast members. Color-coding is understood by the staff, not the women giving birth. As a result, women and family members unfamiliar with the costume design may not be sure who is their nurse.

Well, they would come in and out, you know, because it [my labor] was induced. I didn't know who was who when they came into the room. And so at the beginning I was not nervous; it was just when it started to get intense toward the end, you are like, "Somebody has got to be here with us to help get this baby out!!"

This woman was confused about care provider identity, perhaps because of her own emotional or physical state. As women progress in labor, their orientation moves inward, they become more serious, and they are less likely to be able to relate to time, person, and place.²²

Based on women's birth stories, costumes matter less than nurses' caring behaviors. Caring comes from within the nurse, not from the costume. When nurses demonstrate caring to women, the women express much gratitude and do not generally report confusion regarding who was in their room.

PROPS

Props are the objects that strengthen and support the story. Props are generally used in theatrical productions to add clarity to the action, enhancing the understanding of the plot through visual effects. In theater productions, props are added selectively to avoid distracting from the plot. However, in hospitals, each birthing room comes fully equipped. The rooms vary in appearance and level of technology. Additional equipment is stored but readily available. In hospitals, if a piece of equipment is present, it tends to get used,¹⁴ leading to the possible overuse of interventions even in low-risk hospital births.

A common prop is the electronic fetal monitor. While monitoring of the fetal heart tones is critical for the well-being of the mother and the fetus, evidence suggests that continuous electronic fetal monitoring (CEFM) is overused. When CEFM is compared with intermittent auscultation, CEFM does not offer a significant benefit to normal laboring women. Instead, low-risk women who receive CEFM have been shown to have an increased Caesarean birth rate without improved outcomes.²³⁻²⁴ Despite these findings, CEFM is a common prop in many women's birth stories. Nurses have an important role in advocating the use of technology appropriately, according to the scientific research.^{24,25}

Props also physically support the birthing woman's position. Some props are built into the birth bed, such as the squat bar and footrests. Other types of birthing props need to be brought into the labor or birth room. Out-of-hospital birthing centers may incorporate a variety of props, including a birthing stool. In home births, the family's personal belongings become the props of the labor and birth scene. Therefore, props vary according to the setting.

Further, women may bring props into the hospital. For example, some women pack a "Birth bag" or "Lamaze bag" filled with items used for comfort measures they learned about during childbirth preparation classes. Items may include a picture or stuffed animal to use as a focal point, a tennis ball or rolling pin to enhance back rubbing, a selection of musical tapes to enhance relaxation, and a pillow from home to make the set (or environment) more personally comforting. In addition to the Lamaze bag, some women might bring a bean bag chair to vary positions or a crock-pot to keep warm compresses readily available. Other women might use a birthing ball or tub of some type. Thus, a variety of props support the action and strengthen the plot.

Nurses use a variety of strategies that involve props to assist women in labor and birth. Most commonly, nurses employ creative strategies to improve the comfort and progress of women who require CEFM. For example, nurses may arrange the room so that a woman can comfortably sit in a chair while having CEFM during a pitocin induction. Nurses also commonly advocate for their patients to have bathroom privileges so that women can avoid the use of the bedpan and access the shower or

tub. Subsequently, simple interventions such as sitting in a chair or a bathroom can facilitate the natural processes of descent and normalize the experience for the laboring woman. Nurses often model these creative strategies to other members of the health care team.

Administrators who encourage creativity in nursing care help promote the use of labor comfort aids. For example, administrators may support the use of clinical ladders for the evaluation and promotion of staff nurses that recognize nurses' unique approaches with clients. Nurses commonly use nontechnologic approaches to provide comfort and promote progress during labor ²⁶ limited only by the providers' activity orders. Application of the research evidence on the safety of interventions such as maternal positioning ¹⁸ and hydrotherapy ²⁷ will continue to promote nurses' creative use of props.

SET: THE ENVIRONMENT

In theatrical terms, the stage set is the background designed with specific scenery. The stagehands change the scenery and props to create a particular atmosphere on stage. Noise, lights, and movement in the audience may distract the actors and members of the audience. The setting tremendously influences the cast and the atmosphere of birth.

Labor is a time of great vulnerability. The human birth environment is difficult to study because of the multifactorial nature of the event and the setting. A classic animal study, however, was done by Newton, Peeler, and Newton. ²⁸ The researchers studied 100 laboring mice, randomized into three different birth settings. The researchers were able to stop the labors of mice by moving them, placing them with unfamiliar objects and odors, and removing privacy. This study provided an example of a relevant animal model for mammalian birth. Most mammalian species typically labor and give birth in quiet, dark environments. If they sense a threat, contractions stop and they move to a safer environment to continue labor and give birth.

Recently, Odent ²⁹ expanded on this concept and applied it to human birth in his center in France where he observed women laboring and delivering with support but without directions from the midwives. Odent ³⁰ concluded that a quiet, warm, and dark room in which a laboring woman feels protected, safe, and free from intrusions is necessary for her to reach a point where she is exercising less intellectual control of her brain. He stated that women needed to be undisturbed and able to tune out the external world to allow the contractions and other sensations that they are experiencing to unfold and birth to occur. Odent contended that more primitive control of the birth process occurs spontaneously in the hypothalamus rather than by a woman analyzing and trying to control her responses using the neocortical part of her brain. He stated his approach was linked with positive maternal and neonatal outcomes, although more controlled research in this area is needed.

In contrast, most women give birth in hospitals and need to adapt to a foreign environment with unfamiliar noises, odors, people, and objects. Nurses who have practiced in settings with separate labor and delivery rooms observed a common phenomenon: contractions stopped when the women were moved from the labor room to the delivery room. This may have been due partly to the physiologic resting phase of the second stage of labor. ³¹ Changes in the environment may also play a role in labor stoppage. More research is needed in this area. Women who choose to give birth at home in a familiar environment may not experience this labor-stopping phenomenon. Yet for some women, an underlying fear may overcome their desire to have a home birth, and on rare occasion this may lead

to transfer to a hospital birth setting. While certain women prefer quiet and dark labor environments, this is not the case for all women. Others find themselves in noisy birth environments, full of visitors, conversations, telephone calls, television, and music. For some women, this may be a familiar environment that is not uncomfortable. There are clear distinctions among environments, and women may respond differently in various settings.

Women often described the interruptions they experienced in their birth environment. While it was possible for nursing staff to work together unobtrusively as a team to prepare for the birth of an infant, this was often not the case. As birth became imminent, many mothers recounted changes in the environment: a frantic pace, bright lights, and the presence of too many people. One woman described the transformation of the birthing room:

So the doctor came in and so did all this equipment and everything and things just started to happen. The ceiling dropped and there was a light, a big huge light over me. All of a sudden everything materialized. I mean, you know, people putting gloves on, there were three student nurses, one or two other nurses, the guy who checks the vitals, and that is all I remember.

Sometimes women reported their wishes were lost in the frenzied pace and routine hospital practices. One woman critiqued the situation: "I feel that they really dropped the ball completely. I feel that it was really a circus, you know. I think they really made a mess. In the end, everything was fine but what a zoo!!"

The circus is a unique form of theater where multiple acts are occurring simultaneously. For this woman, the chaos detracted from what should have been her center-stage performance in her own birth experience.

It is evident from women's stories that the birth environment needs to be altered to better meet their needs. Nurses can advocate for laboring women by lowering lights, limiting noise, and monitoring the number of supporting cast members in the birthing room. Lowering lights, removing stress, and offering soothing words all help to create an optimal birth environment where the woman is free to find her own coping style. Thus, nurses have a role in protecting and modulating the environment. In such an atmosphere, labor and birth can be viewed as a series of sacred private moments instead of a circus sideshow. Like theater, labor and birth are enhanced when the lights are low and a loved one is near enough to touch.

BEHIND THE SCENES

In theatrical terminology, "behind the scenes" refers to the parts of theater that take place outside of public view. Actors, like most artists, draw on their life experiences in their work. Some experiences can exert a negative influence. For example, preconceptions about characters and roles can limit an actor's range of expression.

All the actors in the theater of birth bring "old baggage" with them to the scene. Old baggage includes experiences and expectations, both good and bad. Providers and women bring expectations about how events will unfold. Women consider their previous birth experience, as well as what they have heard from others. In addition, previous life experiences can affect childbirth. One example of old baggage that a woman may bring is a history of sexual abuse. It has been estimated that as many as 25-55% of

all women in the USA have experienced some form of sexual abuse.^{32,33} For these women, the sensations of birth, such as pressure or burning, can stimulate flashbacks and troublesome memories.³⁴ An abuse history may be hidden behind the scenes but can exert a profoundly negative influence on the birthing experience.

Another influence operating behind the scenes is the mass media, which affects a woman's expectations for a perfect performance. One multiparous woman reflected on her labor performance expectations developed during childbirth classes:

On the videos that I've seen of labor, I thought that that was normal. They [the women in the videos] were in control, they did the great breathing, they did the walking. When it came to the actual time, they did the focusing, they did a little bit of being upset but they did all the breathing right, right up until the birth. They're not yelling, they're not screaming, and they're not writhing in agony, even though they obviously looked in pain. They get through the whole contraction without any performance [laughs]. I thought that was what I was expected to do, you know [to be] up to par. [In my second labor,] I was doing my breathing, I was being very good. I said this time I'll do [it right], be the model. [However, after a 20-minute ride to the hospital, I was] yelling-an absolute disaster [horizontal ellipsis] absolutely hopeless. I knew all that, but it didn't occur. [The nurse] tells me I "did wonderfully-[that I] was great."

However, this woman concluded that she did not meet the perfect performance standards set in the videos.

In addition, health care providers are influenced by their personal birth experience(s) and/or unusual births they have attended. Generalizing to all births from these unique experiences can cause providers to intervene more readily in attempts to avoid unfavorable situations and repeat pleasant ones. Factors that influence birth from behind the scenes are often overlooked.

Nurses' awareness of women's previous experiences with births and even the women's birth stories may help them develop a comprehensive plan of care. As noted by the previous examples, a positive message from the nurse following a difficult birth experience can affect a woman and create positive lifelong memories. As Simkin⁷ noted, women remember the words that nurses said to them for the next 20 years.

SCRIPT

In theater, the script is the written text of the production. It is prepared, refined, and rehearsed to convey the best story. Actors are encouraged to follow the written script and are discouraged from improvising. A woman's birth plan may be viewed as one version of the script, albeit a somewhat idealized version. The actual birth story becomes the script improvised by the woman in labor, and what she eventually tells others.

Table 5 contains a scriptlike rendition of events that was adapted into dialogue from a birth story narrative, reported by a woman interacting with her nurse. Anthropologists have used a similar research method to study vignettes^{35,36} within birth stories as if they were scripts, allowing analysis of the interactions. For example, in the Table 5 script of a vignette, the nurse initially starts the woman pushing, then later tries to stop her. Through the nurse's actions, the physician is also essentially

exerting control over the timing of the birth, even in his absence. The woman also exerts control by consciously choosing to follow her pushing urges.

Table 5. A birth script

Role	Dialogue
Nurse:	Do you want to push? Go ahead and push.
Woman:	Finally! [And I pushed for awhile.]
Nurse:	[Starting to get really concerned about where the doctor was.] Why isn't he her? ... I don't want to deliver this baby.
Woman:	Have you ever had to deliver a baby?
Nurse:	Just once or twice. [After a pause]. ... I don't get paid enough to deliver babies.
Woman:	[I started to laugh. I came out of my cloud of pain and laughed.] I understand exactly what you mean ... being in jobs where I didn't get paid enough to do all the things that I do. " [Then I went right back into it, pushing, and the head must have started to really come out.]
Nurse:	[Concerned.] Where is he [the doctor]?" ? [Pause.] Where is he [the doctor]?"
Woman:	[I knew both the resident and medical student were busy with another delivery I had three more pushes or something, and at one point they transformed the bed into a delivery cart Now I'm feeling in control for the first time, after about 10 hours of labor I'm pushing with everything I had I remembered the head was almost out Then I felt that head come out and I knew that was ... the hard part..] My doctor arrived, just before the baby.

Control by providers is pervasive in various roles played in the theater of birth. Research by VandeVusse ^{8,9} and others ³⁷⁻³⁹ has demonstrated that there is a preponderance of provider control during labor. Yet Simkin ⁴⁰ has shown that encouraging women to be active participants in their births is related to their long-term positive memories, self-images, and abilities to mother.

The interactions in the script may appear somewhat comedic or farcical, but they serve to illustrate the impact of nurses during labor. Even when only a few lines of dialogue are attributed to the nurse, control was exerted over the laboring woman, as shown in the Table 5 script. It is possible that at times the women may have chosen to write different scripts, but they report what actually occurred from their perspectives.

ROLES: ACTING THE PART

In theater, roles are characters portrayed by actors. The roles of stage actors are clearly described and awarded to those best suited for the part. Certain talents are rewarded with particular roles and linked to differing levels of respect and status. Roles in the theater of birth are often predetermined. However, most often the birthing woman is expected to take the patient's role. For example, in a classic work, Davis-Floyd ⁴¹ noted that a laboring mother is given the patient role in a hospital when she is transported to the birthing unit in a wheelchair, puts on a hospital gown, and experiences other customary admission practices. Once adapted to the patient role, women often attempt to adjust to meet further staff members' expectations, such as following directions and complying with procedures.

One multiparous woman concluded that she did not meet what she thought were the nurse's expectations during her first labor. When she changed position, her monitor tracing became unreadable.

They had me on my back, you know, sitting up a little bit on the bed, and it'd be not comfortable at all. Whereas now they have, they tell you to lay on your side when they put the monitor on and they adjust it. But I remember feeling bad when I moved around 'cuz I'd lose the beat and then they'd have to come in and adjust it. And I'm sure maybe part of that was my feelings of inadequacy.

This woman's repeated need for nurses to adjust her monitor belts whenever she moved ultimately affected how she felt about her overall performance during labor.

One primigravida initially wanted to push, but was examined several times by a resident and medical student and was not completely dilated. In the following example, the nurse correctly interprets the woman's reactions and works to adjust the environment to meet the woman's needs rather than the physician providers' predictions.

He [the doctor] goes, "You are at 5, you know this could take all day." I said, "I know." Like, about 10 minutes later my [bag of] water broke and then the next thing I knew, they were starting to get everything ready. I am saying, "Why are you getting all this stuff ready?" They had checked me. I was at 6 [centimeters out of 10]. She [the nurse] goes, "Well, I have a feeling that you are going to have this baby pretty soon. Let me check you in a minute." She checked me and I was at 9 [centimeters out of 10].

This example illustrated several attempts at provider control through examinations, predictions made by the characters in different roles, the inherent uncontrollability of labor progress, as well as the nurse's role in listening to the woman and believing her embodied knowledge.

Nurses play a role in intrapartal decision making. VandeVusse ⁸ analyzed women's birth stories and identified the different ways women reported that providers (including nurses, midwives, and physicians) affected their decision making. The more women were involved and informed, the more positively they reported their emotions related to decisions that were made during the course of labor. As Hanson ^{42,43} identified, certified nurse-midwives (CNMs) play roles that influence second stage positioning by allowing women choices. Clients of CNMs commonly delivered in sitting or side-lying positions, far different from the lithotomy position that is often imposed in hospital settings. By offering options to laboring women, nurses may help the birthing woman play the starring role as active decision maker.

Simkin ⁷ stated that intrapartum nurses' roles rarely continue after labor is completed. Therefore, they have limited awareness of the long-term impact of their words and actions on the women and their families. In a classic work, Affonso ⁴⁴ suggested that nurses assist postpartum women in reviewing their intrapartum experiences, to fill in gaps in information, and to integrate the labor and birth events into their lives. By encouraging immediate postpartum reviews of their experiences, nurses may assist women to express and sort their feelings about what occurred. ⁴⁵ Nurses can also use this opportunity to praise the woman for her accomplishment of delivering her infant, thus reinforcing her self-esteem and her role as star of the production.

CLINICAL IMPLICATIONS DRAWN FROM THE ANALOGY

In this article, data from two qualitative studies on aspects of labor and birth were triangulated or merged. An analogy was developed from these data to elucidate women's experiences and to offer new perspectives on labor and birth. Birth, like theater, can be used to convey important messages within our culture. These messages, told in story form, can be used to create far-reaching emotional impacts or meanings. The impact can result in reflection on one's own experiences and may motivate providers to modify their current behaviors and practices. Viewing exchanges between nurses and their patients as dialogue in scripts (see Table 5) allows perinatal nurses to decide the roles they want to play in women's birth experiences.

Nurses can also use the research evidence and consumer preferences to emphasize to administrators the critical need for nurses' roles in labor support. For example, the nurse's physical presence at the bedside of laboring women needs to be valued. Central monitoring may result in limiting the nurse's time for bedside care in an attempt to stretch a nurse among several laboring women. The use of intermittent auscultation for the care of low-risk women can result in a reorientation of the nurse's role to remaining at the woman's side.²³ Labor support and continuous physical presence by the nurse are supported by research, appreciated by consumers, and linked to improved perinatal outcomes.²⁰

As members of the production staff in general, nurses can alter the set (environment). By applying relevant research they can enhance the quality of the overall production. Nurses hold prominent roles and become permanent parts of the birth story of every woman and family with whom they come in contact. Given that women remember their births with accuracy for over 20 years^{6,7} and probably for their entire lifetimes, nurses would want to be remembered in positive regard.

In the Wizard of Oz, the parting words of the wizard to Dorothy are that what is important is how others remember you, not what you remember of others. Perinatal nurses devote their professional lives to the care of birthing women and their families. The legacy of care given lives in the memories of those individuals. It becomes like a videotape that is rewound and replayed for the rest of the woman's life. Nurses have a powerful role in making the "tape" one the woman and her family can enjoy reviewing for years to come.

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